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April 19, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Cervical Epidural Steroid Injection (C7-T1) Center CPT Code 62310

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Pain Management Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on XX/XX/XX, after falling off the X while working as a XX.

On XX/XX/XX, the patient was evaluated for evaluation and treatment of left total elbow arthroplasty following failed open reduction, internal fixation (ORIF) done on XX/XX/XX. The patient had not used the compression stuff since previous therapy visit because of hand swelling. He took it off and the swelling was going down. The swelling had decreased but he still could not make a full fist on his own. Pain at the elbow was 4/10, wrist/hand was 9/10; and shoulder was 7/10. Diagnoses were pain in left elbow, left limb swelling, left elbow joint replacement status, pain in left hand, pain in left shoulder region and left rotator cuff tear. Treatment modalities included therapeutic exercises, manual therapy, and home exercise program (HEP).

On XX/XX/XX, the patient was evaluated for a follow-up visit of left wrist pain. He was initially treated with an ORIF of the elbow which failed and then he went on to total elbow arthroplasty. He

had had pain and swelling in his wrist since the injury. He rated the pain at 7/10. It was sharp and intermittent. There was associated giving way. He also reported intermittent numbness and tingling radiating up and down his arm. Examination revealed the posterior elbow incision was pristine with no signs of infection or drainage. He could make a fist and fully extend his digits. He had some discomfort on full tight fist formation. There was moderate tenderness over the radiocarpal joint. X-rays of the left wrist revealed an apparent healed fracture deformity at the base of the fifth metacarpal. XX assessed left wrist sprain following high-energy fall. XX suspected that the patient was suffering from soft tissue aggravation and inflammation from the fall. A removable wrist splint was provided. Plan was to continue therapy. XX stated that if the patient had pain for 6-8 weeks then an magnetic resonance imaging (MRI) would be ordered.

On XX/XX/XX, XX noted the patient was on Norco, oxycodone and Xarelto. Examination revealed he had full extension and flexion to 120 degrees. There was no erythema or warmth of the elbow. He continued to have pain in the shoulder but no weakness with rotator cuff strength testing. XX assessed elbow pain, shoulder pain, history of left shoulder AC joint separation, continued left shoulder pain, and left total elbow arthroplasty. XX felt that the patient's condition could be from a frozen shoulder though his MRI was essentially normal. Restrictions of no lifting more than 5-10 lbs with the left arm were continued.

On XX/XX/XX, XX evaluated the patient for follow-up of his left wrist. The patient reported ongoing swelling. His pain was present but not that limiting in his wrist. Overall he was doing well. Examination revealed he had some mild tenderness over the radiocarpal joint and mild carpometacarpal tenderness of the left thumb. He had mild-to-moderate ulnar tenderness. X-rays of the left wrist revealed no obvious bony abnormality. There was some carpometacarpal arthritis and metacarpophalangeal arthritis of the thumb. XX opined the patient was fairly asymptomatic with regards to the left wrist and did not need any further intervention and would be seen on an as-needed basis.

On XX/XX/XX, XX evaluated the patient. Plan was to continue PT.

On XX/XX/XX, XX evaluated the patient. MRI was within normal limits with some minor degenerative changes but the patient continued to have pain extending into his axillary region and lateral deltoid region into the shoulder blade region. A corticosteroid injection the previous week had not provided any relief and he reported rolling over in bed with excruciating pain the last weekend. It had been significantly worse since then. Examination revealed full extension and flexion to 135 degrees at the elbow. He continued to have pain with any sort of ROM with the shoulder but no true loss of motion. Strength testing was difficult because of elbow limitations. Mild tenderness over the acromioclavicular (AC) joint was noted. X-rays of the cervical spine showed multilevel spondylosis on the left side at the C4-C5, C5-C6 and C6-C7 levels. XX additionally assessed possible cervical radiculopathy with cervical spondylosis. An MRI of the cervical spine was ordered. A Medrol Dosepak was prescribed.

On XX/XX/XX, XX evaluated the patient. The wrist was getting better. The numbness down the

back of the arm came and went and he could not lift the arm very much. His pain level was 3/10 in the elbow, 4/10 at wrist/hand, and 7/10 in the shoulder. XX assessed the elbow and wrist was progressing. There was ongoing stability weakness in the elbow but he was able to function. The patient underwent PT modalities including therapeutic exercises and manual therapy. Therapy was to be held until the cervical issue was determined.

On XX/XX/XX, an MRI of the cervical spine was completed. The study revealed right convex curvature with superimposed multilevel degenerative disc, endplate and facet disease including findings of active facet degeneration on the left at C3-C4, mild/moderate C3-C4 and mild C5-C6 canal stenosis, no significant mass effect on the cord or cord impingement at any level, prominent left-sided foraminal stenosis at levels C2-C3 through C5-C6 corresponding to the left C3, left C4, left C5 and left C6 nerve roots respectively.

On XX/XX/XX, XX noted the Medrol Dosepak had provided some relief. The patient continued to have pain on the posterior aspect of the shoulder with no real restrictions in ROM of the shoulder. Pain was localized to the lateral deltoid and scapular region. XX reviewed the MRI and assessed shoulder pain, cervical spondylosis with radiculopathy, and left cervical spondylosis and foraminal stenosis. Referral to physical medicine and rehabilitation (PM&R) was recommended. The patient was advised to complete his Medrol Dosepak.

On XX/XX/XX, the patient was evaluated for neck pain with radiation into the shoulder. The patient stated the pain was to his lower neck and radiated down into the shoulder and down the left arm. It was moderate, constant and he had already received treatment for it including injection, over-the-counter medication, activity modification/rest, prescription medication, therapy and bracing. He reported occasional numbness and tingling. He had had a shoulder injection with no relief. Examination revealed grossly intact sensation in the C3-T1 dermatomes except for mild paresthesia of the left thumb through third digits. There was head forward posture and loss of normal cervical lordosis. Cervical ROM was decreased and limited by pain. Muscle strength was limited for left shoulder abduction, elbow flexion and extension. XX diagnosed cervicalgia and cervical radiculitis and recommended one cervical epidural steroid injection (ESI) for diagnostic purposes. If not better after injection then the patient was advised left upper extremity electromyography/nerve conduction study (EMG/NCS). She advised the patient to avoid bedrest as it has not been shown to help with spine pain.

In a utilization review, XX denied the request for cervical epidural steroid injection, center level C7-T1, 62310. Rationale: "*The patient is a male who sustained an injury on XX/XX/XX when he fell. The patient is diagnosed with cervicalgia, cervical radiculitis, and mild-moderate C3-4 and mild C5-6 canal stenosis. A request is made for outpatient cervical epidural steroid injection at level C7-T1. Prior treatments include medications and PT. Cervical spine MRI dated XX/XX/XX revealed right convex curvature with superimposed multilevel degenerative disc, endplate and facet disease including findings of active facet degeneration on the left at C3-4. There is mild-moderate C3-4 and mild C5-6 canal stenosis. There is no significant mass effect on the cord or cord impingement at any level. There is prominent left-sided foraminal stenosis at levels C2-3 through C5-6 corresponding to*

the left C3, left C4, left C5 and left C6 nerve roots respectively. The most recent medical report dated XX/XX/XX states that the patient has neck pain with radiation to the shoulder. The pain is in his lower neck which radiates down into the shoulder, and radiates down the left arm. There is occasional numbness and tingling. This began months ago and started after a work-related injury (xxxxx) requiring left elbow arthroplasty by XX. Previous treatment has included injection, over the counter medication, activity modification/rest, prescription medication, therapy, and bracing. Medications include Medrol Pak, Norco, oxycodone and Xarelto. On physical examination of the cervical spine, there is grossly intact sensation in the C3-T1 dermatomes except for mild paresthesia in the left thumb through the 3rd digits. There is decreased range of motion. Muscle strength is 5/5 in the C5-T1 myotomes except for left shoulder abduction, elbow flexion and extension limited by pain. Cervical spine Epidural Steroid Injection was recommended. Although the patient has cervical spine pain and radicular symptoms, the referenced guidelines do not recommend epidural steroid injection at the cervical spine based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. As such, the medical necessity of this request has not been substantiated."

On XX/XX/XX, a reconsideration appeal was denied. Rationale: *"The patient is a male who sustained an injury on XX/XX/XX when he fell. The patient is diagnosed with cervicalgia, cervical radiculitis, and mild-moderate C3-C4 and mild C5-C6 canal stenosis. An appeal request is made for outpatient cervical epidural steroid injection at level C7-T1. The previous request was denied because the referenced guidelines do not recommend epidural steroid injection at the cervical spine based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. Prior treatments include medications and PT. Cervical spine MRI dated XX/XX/XX revealed right convex curvature with superimposed multilevel degenerative disc, endplate and facet disease including findings of active facet degeneration on the left at C3-C4. There is mild-moderate C3-4 and mild C5-6 canal stenosis. There is no significant mass effect on the cord or cord impingement at any level. There is prominent left-sided foraminal stenosis at levels C2-3 through C5-C6 corresponding to the left C3, left C4, left C5 and left C6 nerve roots respectively. The medical report dated XX/XX/XX states that the patient has neck pain with radiation to the shoulder. The pain is in his lower neck which radiates down into the shoulder, and radiates down the left arm. There is occasional numbness and tingling. This began months ago and started after a work related injury (fell from X) requiring left elbow arthroplasty. Previous treatment has included injections, over the counter medication, activity modification/rest, prescription medication, therapy, and bracing. Medications include Medrol Pak, Norco, oxycodone, and Xarelto. On physical examination of the cervical spine, there is grossly intact sensation in the C3-T1 dermatomes except for mild paresthesias in the left thumb through the 3rd digits. There is decreased range of motion. Muscle strength is 5/5 in the C5-T1 myotomes except for left shoulder abduction, elbow flexion and extension limited by pain. Cervical spine Epidural Steroid Injection was recommended. An updated medical report addressing the issues of the previous determination was not submitted. Although it was noted that the patient has evidence of cervical spine radiculopathy as evidenced by mild paresthesia in the left thumb through the 3rd digits and decreased strength with left shoulder abduction, and left elbow flexion and extension, ODG does not recommend epidural steroid injection at the cervical spine based on recent evidence, given the serious risks of this*

procedure in the cervical region, and the lack of quality evidence for sustained benefit. In agreement with the previous determination, the medical necessity of the request has not been established.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**